Administrative Code

Title 23: Medicaid
Part 221

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Part 221 Chapter 1: General

Rule 1.1: Purpose

States are required to provide family planning services and supplies, directly or under arrangements with others, to individuals of childbearing age, including minors who can be considered to be sexually active, who are eligible under the State plan and who desire such services and supplies.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1905(a)(4)(c)

Rule 1.2: Freedom of Choice

A. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services in accordance with Part 200, Chapter 3, Rule 3.6.

B. Beneficiaries have freedom of choice in deciding to receive or reject family planning services. Beneficiaries have the freedom to choose family planning providers. Beneficiaries may choose any method of birth control, including sterilization. Providers must ensure that information is given in such a way as to encourage and support free choice.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1902(a)(23)

Rule 1.3: Beneficiary Cost Sharing

Family planning services are exempt from co-pay requirements in accordance with Part 200, Chapter 3, Rule 3.7.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 447.50-447.59; Social Security Act § 1902(a)(14)

Rule 1.4: Covered Services

A. Family planning services are services provided to eligible beneficiaries who voluntarily choose to prevent pregnancy, plan the number of pregnancies, or plan the spacing between pregnancies.

B. Family planning services are provided, with limitations, in the following general categories:

    1. Visits- Counseling and education are considered part of the family planning visit and must not be billed separately.

2. Contraceptive Drugs

    a) Insertion and removal of contraceptive implants are covered.

    b) Contraceptive injections administered in the provider's office are covered.

    c) Prescription contraceptives are available through the pharmacy program.

3. Contraceptive Devices

    a) Insertion and removal of contraceptive intrauterine devices are covered.

    b) Diaphragm or cervical caps fitting with instructions are covered.

4. Voluntary Sterilization - Vasectomy and tubal ligation procedures, including tubal ligation by hysteroscopy, are only covered if they meet Medicaid criteria for sterilization as outlined in Part 202, Chapter 1, Rule 1.7.(A)(B)(F).

5. Laboratory Procedures - Pap smears and screening for sexually transmitted diseases are covered services.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(13); Social Security Act § 1905(a)(4)(c)

Rule 1.5: Non-Covered Services

A. Services and items that are not considered family planning services include, but are not limited to, the following:

1. Facilitating services such as parking and child care while family planning services are being obtained.

2. Indirect services, such as telephone contacts/consultations.

3. Drugs used to promote fertility.

4. Emergency contraceptives and related services.

5. Over-the-counter drugs and supplies including, but not limited to, pregnancy tests, condoms, and spermicides.

6. Infertility studies, procedures to enhance fertility including reversal of sterilization, artificial or intrauterine insemination or in-vitro fertilization.

7. Abortions and related services.

8. Hysterectomy and related services.

9. Menopausal/post-menopausal treatment and related services.

10. Removal of an implanted device, if the beneficiary is not Medicaid eligible when it is time for the device to be removed.

11. Natural Family Planning services.

12. Mammograms.

13. Ultrasound and radiology.

14. All services provided for the treatment of medical conditions including medical complications of a family planning service.

15. Cancer screening services, except for pap smears.

16. Services to a beneficiary whose age or physical condition precludes reproduction.

17. Services to a beneficiary known to be pregnant.

18. Services outside the scope and/or authority of the provider's specialty and/or area of practice.

Source: Miss. Code Ann. § 43-13-121

Rule 1.6: Documentation/ Record Maintenance

A. Providers of family planning must comply with the requirements for maintenance of records outlined in Part 200, Chapter 1, Rule 1.3.

B. At a minimum, Family Planning documentation must include the following on each beneficiary:

1. Signed and dated consent for treatment, if applicable;

2. Signed and dated consent for sterilization, if applicable;

3. Date of service;

4. Demographic information, including name, address, Medicaid number, date of birth, sex, and marital status;

5. Medical history, past and current;

6. Family history when appropriate;

7. Allergies, including type, reaction, and treatment;

8. Specific name/type of all diagnostic studies, such as laboratory, and the result/finding of the studies;

9. Treatments/procedures rendered;

10. Physical findings;

11. Medications: Documentation must reflect all drugs, including contraceptives, whether administered by the provider, prescribed, or issued via samples. Documentation must include the name of the medication, strength, dose, and route. The method of administration and site must be included for all injectable medications. Documentation must reflect whether prescriptions were issued in writing or by telephone;

12. Contraceptive supplies, which includes record of all a drugs, including contraceptives, whether administered by the provider, prescribed, or issued via samples;

13. Contraceptive devices;

14. Contraception counseling;

15. Date, time, and signature for all entries in the beneficiary record; and

16. Order, including time, date, and signature, for all medications, treatments, and procedures rendered.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129

Rule 1.7: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of this Title, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 221 Chapter 2: 1115 Demonstration Waiver

Rule 2.1: Purpose

A. The Family Planning Services Section 1115 Demonstration Waiver allows the State of Mississippi to extend Medicaid eligibility for Family Planning services to all women of childbearing age with incomes at or below one hundred eighty-five percent (185%) of the federal poverty level who would not otherwise qualify for Medicaid. Childbearing age is defined as ages thirteen (13) through forty-four (44). Women who are served in this waiver

will be able to secure family planning services through the Mississippi Medicaid program.

B. Beneficiaries enrolled in the Family Planning Waiver Program receive a Yellow Medicaid Identification Card. The yellow card signifies that the beneficiary is eligible for family planning waiver services only. Providers are responsible for verification of covered services and beneficiary eligibility.

Source: Miss. Code Ann. § 43-13-121

Rule 2.2: Eligibility

A. The Family Planning Waiver limits eligibility to females age thirteen (13) through forty-four (44) who meet the following criteria:

1. Individual has a family income at or below one hundred eighty-five percent (185)% of the federal poverty level;

2. Individual is not pregnant and has not had a medical procedure that would prevent pregnancy, such as tubal ligation or hysterectomy;

3. Individual is uninsured, and is not enrolled in Medicare, Medicaid, or the State Children's Health Insurance Program (SCHIP);

4. Individual is a U.S. citizen or documented immigrant; and

5. Individual is a Mississippi resident.

B. Individuals eligible for the program will remain eligible for twelve (12) months, or for the duration of the program if less than one (1) year. Recertification will be performed at the end of each year of eligibility.

C. Automatic Eligibility - Women between ages thirteen (13) through forty-four (44) who are eligible for the Medicaid pregnancy program and have reached the end of their sixty (60) day postpartum period will be automatically enrolled in the family planning waiver. A separate application is not required if individual is uninsured. The individual will be notified by mail of eligibility for services.

D. Loss of Eligibility- A loss of eligibility will occur when one (1) of the following occurs:

1. Beneficiary moves from the state of Mississippi;

2. Beneficiary loses Medicaid eligibility;

3. Beneficiary becomes eligible for another Medicaid program, Medicare, or obtains health insurance;

4. Beneficiary requests closure, or termination of family planning waiver services;

5. Beneficiary has a procedure that prevents pregnancy, such as a hysterectomy or a tubal ligation;

6. Beneficiary is deceased; or

7. Beneficiary turns forty-five (45) years old.

E. Dual Eligibility / Informed Choice - In cases where a Family Planning Waiver applicant is also eligible for Medicaid or State Children's Health Insurance Program (SCHIP), the applicant will be notified and allowed to make an informed choice between the programs.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(42); Social Security Act 1115; Social Security Act 1915(b)

Rule 2.3: Freedom of Choice

A. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services in accordance with Part 200, Chapter 3, Rule 3.6.

B. Beneficiaries have freedom of choice in deciding to receive or reject family planning services. Beneficiaries have the freedom to choose family planning providers. Beneficiaries may choose any method of birth control including sterilization. Providers must ensure that information is given in such a way as to encourage and support free choice.

Source: Miss. Code Ann. § 43-13-121; Social Security Act 1902(a)(23)

Rule 2.4: Covered Services

A. Family planning waiver services are services provided to eligible beneficiaries who voluntarily choose to prevent pregnancy, plan the number of pregnancies, or plan the spacing between pregnancies**.**

B. Family planning waiver services are provided, with limitations, in the following general categories:

1. Visits: Visits must be for the purpose of family planning. Counseling and education must be included as a part of the family planning visit.

a) The initial visit is the first time a beneficiary receives family planning services. This visit includes the establishment of medical records, an in-depth evaluation including a medical history, a complete physical exam, establishment of baseline laboratory data, contraceptive and sexually transmitted disease prevention counseling, issuance of supplies or prescription, and family planning counseling and education.

b) The annual visit is the re-evaluation of an established patient. These visits include an update to medical records, interim history, complete physical examination, appropriate diagnostic lab tests or procedures, and family planning management, education and counseling.

c) The periodic revisit is a follow-up evaluation of an established patient with a new or existing family planning condition. These visits are for evaluation of a new contraceptive, contraceptive changes or contraceptive problems.

d) Office visits are limited to four (4) annually.

2. Contraceptive Drugs: Beneficiaries enrolled in the Family Planning Waiver are eligible for Medicaid coverage of family planning services only and are not eligible for other Medicaid pharmacy services. These drugs include:

a) Oral contraceptive agents;

b) Topical patches;

c) Self inserted contraceptive products;

d) Injectable contraceptives are available through the pharmacy program;

e) Contraceptive injections administered in the provider's office; and

f) Prescription contraceptives as available through private providers enrolled in the Mississippi State Department of Health's family planning program.

3. Contraceptive Devices

a) Insertion and removal of contraceptive intrauterine devices;

b) Insertion and removal of contraceptive implants;

c) Diaphragm or cervical cap fitting with instruction; and

d) Vaginal rings are covered.

4. Voluntary Sterilization: Tubal ligation procedures, including tubal ligation by hysteroscopy, are covered only if they meet Medicaid criteria for sterilization as outlined in Part 202, Chapter 1, Rule 1.7.(A)(B)(F).

5. Laboratory Procedures, Initial and Annual Visits: Laboratory procedures that must be conducted during initial and annual visits include the following:

a) Hematocrit;

b) Urinalysis;

c) PAP smear;

d) STD/HIV tests; and

e) Pregnancy test, as indicated

Source: Miss. Code Ann. § 43-13-121; 43-13-117(42) Social Security Act 1115; Social Security Act 1915(b)

Rule 2.5: Non-Covered Services

A. Certain services are not considered family planning services and are not reimbursable under the waiver program. These include, but are not limited to, the following:

1. Facilitating services such as transportation;

2. Infertility studies, procedures to enhance fertility including reversal of sterilization, artificial or intrauterine insemination or in-vitro fertilization;

3. Sterilization by hysterectomy;

4. Therapeutic abortion or any related services;

5. Spontaneous, missed or septic abortions and related services;

6. Inpatient hospital visit;

7. All services provided for the treatment of a medical condition including a medical complication of a family planning service;

8. Removal of an intrauterine device (IUD) because the beneficiary has a uterine or pelvic infection;

9. Emergency contraceptives and related services;

10. Over-the counter contraceptive devices such as condoms, spermicidal and sponges are not covered; and

11. Prescriptions other than contraceptives.

Source: Miss. Code Ann. § 43-13-121; Social Security Act 1115; Social Security Act 1915(b)

Rule 2.6: Quality Assurance

A. The Quality Assurance Plan consists of quality assurance activities designed to:

   1. Ensure the provision of comprehensive, accessible, quality and appropriate services.

   2. Provide a system for accountability and measuring performance.

   3. Improve care outcomes and quality of life.

B. Activities/functions shall be performed by Division of Medicaid program staff in conjunction with the Mississippi State Department of Health quality monitoring and quality improvement activities for their clinics.

   1. Ensure standards of care for family planning waiver services are evidence based best practices.

   2. Conduct periodic on site review of medical records.

C. The Division of Medicaid (DOM) shall conduct periodic on-site reviews of medical records to determine that participants have received appropriate medical care and are appropriately referred for needed primary care.

Source: Miss. Code Ann. § 43-13-121

Rule 2.7: Beneficiary Cost Sharing

Family planning services are exempt from cost sharing (co-pay) requirements in accordance with Part 200, Chapter 3, Rule 3.6.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 447.50 - 447.59; Social Security Act 1902(a)(14)

Rule 2.8: Primary Care Referrals

Health concerns not covered by the family planning waiver identified during a family planning visit must be followed up by a primary care provider and the appropriate clinical referral made. Whenever possible, beneficiaries should be referred to Federally Qualified Health Centers (FQHCs), Community Health Centers, or Rural Health Clinics. As a component of the medical record audit, the primary care referrals must be documented in the beneficiary's medical record.

Source: Miss. Code Ann. § 43-13-121

Rule 2.9: Documentation/Record Maintenance

A. Providers of family planning waiver services must comply with the requirements for maintenance of records outlined in Part 200, Chapter 1, Rule 1.3. At a minimum, Family

Planning documentation must include the following on each beneficiary:

1. Date of service;

2. Reason for visit;

3. Physical findings including vital signs and weight;

4. Treatments/procedures rendered;

5. Demographic information, including name, address, Medicaid number, date of birth, sex, and marital status;

6. Allergies;

7. Medical history, past and present that is updated annually. The history must include social history, in regard to smoking, alcohol, and activity, sexual history including age of onset, and partners, and obstetrical and gynecological history;

8. Family history;

9. Tests and their results;

10. Medications-documentation must reflect all drugs, including contraceptives, whether administered by the provider, prescribed, or issued via samples, etc. Documentation must include the name of medication, strength, dose, and route. The method of administration and site must be included for all injectable medications. Documentation must reflect whether prescriptions were issued in writing or by telephone;

11. Contraceptive supplies-record all drugs, including contraceptives, whether administered by the provider, prescribed, or issued via samples;

12. Contraceptive devices;

13. Contraception counseling;

14. Date, time, and signature for all entries in the beneficiary record;

15. Provider orders-include time, date, and signature for all medications, treatments and procedures rendered;

16. Consents for treatment, as applicable; and

17. Primary care referrals, if applicable.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129